Dental Student and Faculty Perceptions of Uncivil Behavior by Faculty Members in Classroom and Clinic

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Abstract: Uncivil behavior by a faculty member or student can threaten a classroom environment and make it less conducive to learning. The aim of this study was to explore faculty behaviors that dental faculty and students perceive to be uncivil when exhibited in the classroom and clinic. In 2015, all faculty, administrators, and students at a single academic dental institution were invited to participate in an electronic survey that used a five-point Likert scale for respondents to indicate their agreement that 33 faculty behaviors were uncivil. Response rates were 49% for faculty and 59% for students. Significant differences were found between student and faculty responses on 22 of the 33 behavioral items. None of the three category composite scores differed significantly for students compared to faculty respondents. The category composite scores were not significantly associated with gender, ethnicity, or age for faculty or students. Overall, this study found significant differences between students and faculty about perceived uncivil faculty behaviors, though not for categories of behaviors.

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Creating a classroom environment that is conducive to student learning is the responsibility of all higher education faculty members. However, uncivil behavior exhibited by a faculty member or student can threaten this goal. Uncivil behavior in the classroom can create a tense environment, impede learning, and encourage an escalation in aggressive behavior.[1-3] Clark and Springer defined student incivility as "rude or disruptive behaviors often resulting in psychological or physiological distress for target faculty, which, if left unaddressed, may progress into threatening situations."[4] But, what about the influence of "rude or disruptive" faculty behavior on students and the learning environment? Incivility in higher education institutions has largely focused on student incivility and its classroom implications. According to Del Prato, however, four areas of faculty incivility that will lead to an environment that is not conducive to learning are "a) verbally abusive and demeaning experiences, b) favoritism and subjective evaluation, c) rigid expectations for perfection and time management, and d) targeting and weeding out practices,"[5] also supported by the findings in Del Prato et al.[6]

In addition to teaching the content information required of the discipline, the faculty also model the principles of professional behavior. If faculty members consistently engage in uncivil behaviors, students may infer that such behavior is acceptable and reciprocate in kind. This process of socialization is what Bevis and Watson referred to as an "informal (hidden) curriculum."[7] Some students exposed to such an unprofessional learning environment may be socialized to believe such behavior is appropriate in the profession, thus perpetuating uncivil behavior. Others may interpret the behavior as unprofessional

and threatening and avoid contact with the faculty member. In either case, an unhealthy learning environment has now been introduced that will occlude the professional growth and development of students.

The majority of studies concerning faculty incivility in health professions education have been in the field of nursing. Clark stated that "academic incivility is becoming a more common and distressing problem in nursing education."[8] Other studies have reported that uncivil behavior by nursing faculty interfered with safe clinical performance and decreased program satisfaction and retention.[9-11] Faculty incivility has also been reported to increase stress, physical and emotional withdrawal, and possible violence.[10] Researchers have noted that when personal interactions increase in frequency and complexity, as in nursing clinical training, the need for civil behavior increases.[10,12]

While there are no studies in the dental education literature directly addressing faculty incivility, there are studies that explore positive and negative qualities or characteristics of dental educators from both the student and educator perspectives. In a study focusing exclusively on clinical teaching in dental education, students identified several negative attributes of teachers, including being rude to students and patients, being overly critical, and leaving class early or arriving late.[13] An additional study of dental students found that students identified teachers who were impolite, condescending, overly critical, and without unclear objectives as having a negative influence on their learning experience.[14] Those students also reported having a negative experience with teachers who were absent or left class early. A study of classroom teaching preferences among medical, dental, and related graduate residency programs and their graduates revealed negative key words such as "critical," "arrogant," "sarcastic," and "disrespectful."[15] Although these studies focused primarily on the positive attributes of an effective teacher, their qualitative nature provided for some valuable insight into the negative attributes as well.

A general lack of faculty incivility research in many disciplines is said to be due to denial, embarrassment, or unwillingness to change the academic culture.[9,16,17] A prior study by Ballard et al. focused on uncivil dental student classroom behavior as perceived by dental faculty and students.[18] That study noted that future research concerning incivility in dental education should also focus on perceived uncivil faculty behavior. Therefore, the aim of this study was to explore faculty behaviors that faculty and students perceive to be uncivil when exhibited in the classroom and clinic.

Materials and Methods

Approval for administration of the survey was obtained from the Louisiana State University Health Science Center Institutional Review Board. This study used an electronic survey based on a previous survey that investigated perceptions of student incivility.[18] The survey consisted of 39 questions for student participants. For the faculty survey, the first question on the student survey was replaced with the following four, faculty-specific questions: What is your assigned department or division? What is your current year of teaching? Is your position full-time or part-time? Are your responsibilities administrative, didactic, clinical, or both didactic and clinical? Questions two through 39 on the student survey were also used on the faculty survey for a total of 42 faculty questions. Participants responded to the non-demographic questions on a five-point Likert scale (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree). The survey items were categorized as "classroom," "clinic," and "general" behaviors. Item scores were averaged for each of these three categories to compute category composite scores.

The institution is a non-hospital-based, public, U.S. dental school offering degrees in dental laboratory technology, dental hygiene, and dentistry and specialty training in six recognized dental specialties. The target population for the study was all 258 dental students, 75 dental hygiene students, six dental laboratory technology students, and 131 dental school faculty members and administrators. In 2015, the students and faculty members received an email invitation and a personal classroom or faculty meeting invitation to participate in the study. To avoid influencing the participants' perceptions, no definitions or examples of civil or uncivil behavior were provided on the survey or in the invitation to participate. Participation was voluntary, anonymous, and non-compensatory. The survey was available electronically for 30 days via SurveyMonkey (SurveyMonkey.com, LLC, Palo Alto, CA, USA). Responses were collected electronically and downloaded into an Excel spreadsheet (Microsoft, Redmond, WA, USA) for analysis.

The Wilcoxon-Mann-Whitney test and Kruskal-Wallis test were used to compare item scores and category composite scores for dichotomous and nominal independent variables, respectively, and Spearman's correlation coefficient was used to examine associations with quantitative variables. Cronbach's alpha was used to assess internal consistency of the subscale item responses and interpreted according to the guidelines provided by George and Mallery.[19] SAS version 9.4 (SAS Institute Inc., Cary, NC, USA) was used for all data analysis.

Five behaviors (drinking other than water; arriving late; leaving early; answering a non-emergency cell phone call; and non-emergency texting) were common to the classroom and clinic items. In order to determine differences in the perceived degree of incivility for the same behavior in the clinic and classroom, separate classroom and clinic scores were computed for each of the five behaviors. The Wilcoxon Signed Rank test was used to determine significant differences in the perceived degree of incivility of each behavior in the clinic versus classroom. An a priori power analysis was performed assuming a 50% response rate for both faculty and students, based on previous response rates observed with similar surveys at the institution. A 50% response rate would have yielded 66 faculty participants and 170 student participants. Under the assumption that the observed responses to a given survey item would be 44% strongly agree and 14% for each of the other four Likert-scale choices for faculty and 20% for each Likert-scale choice for students, the Wilcoxon Rank-Sum test would achieve 83% statistical power to detect a difference between the two groups at the 5% significance level. The overall response rate for this study was greater than the 50% response rate assumed for this power analysis; thus, even greater statistical power was achieved for comparisons of faculty and students.

Results

The survey was distributed to 339 students and 131 faculty members. Survey responses were received by 201 students and 64 faculty members, yielding a response rate of 59% for students and 49% for faculty.

Of the 201 student responses, the majority were female (62%) and between the ages of 21 and 30 years (92%) (Table 1). Race was reported most commonly as Caucasian (79%), followed by Asian American (10%) and African American and two or more races (3% each). The percentage and number of student respondents for each year and course of study were as follows: Dental 1=22% (45), Dental 2=29% (58), Dental 3=20% (40), Dental 4=14% (28), Dental Hygiene 1=7% (14), Dental Hygiene 2=6% (12), Dental Laboratory Technology 1=1% (1), and Dental Laboratory Technology 2=2% (3) (Table 1). The demographics of dental student respondents to our survey were similar to the demographics of the 2015 entering class of enrollees at U.S. dental schools.[20]

Of the 64 faculty respondents, 63% were male, and 84% were full-time (Table 2). Race was reported most commonly as Caucasian (79%), followed by Asian (11%) and then African American (5%). Faculty respondents most frequently described their responsibilities as both didactic and clinical (44%), followed by administrative and clinical (27%) and clinical (14%). Clinical comprehensive dentistry (20%) and diagnostic services (15%) comprised the largest percentage of faculty respondents. The largest

Table 1. Characteristics of students who completed survey (N=201)

Characteristic	Number (%)
Gender	
Female	122 (62%)
Male	76 (38%)
Course of study and year	
Dental 1	45 (22%)
Dental 2	58 (29%)
Dental 3	40 (20%)
Dental 4	28 (14%)
Dental hygiene 1	14 (7%)
Dental hygiene 2	12 (6%)
Lab technology 1	1 (1%)
Lab technology 2	3 (2%)
Ethnicity	
Caucasian	155 (79%)
African American	6 (3%)
Hispanic/Latino	4 (2%)
Asian	19 (10%)
Other	13 (7%)
Age in years	
≤20	1 (1%)
21-30	184 (92%)
31-40	13 (7%)
>40	1 (1%)

Note: Percentages may not total 100% because of rounding. Some respondents skipped some items.

Table 2. Characteristics of faculty members who completed survey (N=64)

Characteristic	Number (%)
Gender	
Female	23 (37%)
Male	39 (63%)
Ethnicity	
Caucasian	48 (79%)
African American	3 (5%)
Hispanic/Latino	1 (2%)
Asian	7 (11%)
Other	2 (3%)
Age in years	
31-40	7 (14%)
41-50	13 (26%)
51-60	16 (32%)
>60	14 (28%)
Years teaching	
<5	10 (16%)
5-10	19 (31%)
11-20	19 (31%)
>20	14 (23%)
Position type	
Full-time	52 (84%)
Part-time	10 (16%)
Responsibilities	
Administrative	2 (3%)
Didactic	7 (11%)
Clinical	9 (14%)
Administrative and clinical	17 (27%)
Didactic and clinical	28 (44%)

Note: Percentages may not total 100% because of rounding. Some respondents skipped some items.

portion (32%) reported being in the 51-60 age range, with the >60 age range (28%) being the second most common. Current years of teaching most frequently reported were 5-10 years and 11-20 years (31% each), followed by >20 years (23%).

Significant differences were found between student and faculty responses on 22 of the 33 behavioral questions (Table 3). There was not a significant difference in student (mean score 3.4±1.1) vs. faculty (mean score 3.5±0.9) perceptions that faculty incivility exists at the institution (p=0.805). Although none of the three category composite scores differed significantly for students compared to faculty respondents, faculty members agreed significantly more than students that 11 behaviors were uncivil (six classroom, one clinic, and four general behaviors). Students agreed significantly more than faculty members that 11 behaviors were uncivil (three classroom, one clinic, and seven general behaviors), and 11 behaviors were not significantly different (two classroom, six clinic, and three general behaviors). Internal consistency was acceptable for the 11 classroom behavior items (α=0.736) and the 14 general behavior items (α=0.701) and good for the eight clinic behavior items (α=0.831).

For dental students, year of study was inversely correlated with responses to the clinic behavior items (r_s=-0.199, p=0.010), but was not significantly associated with responses to classroom behavior items (r_s=-0.081, p=0.294) or general behavior items (r_s=-0.055, p=0.476). Course of study (dental, dental hygiene, dental laboratory technology) was not significantly associated with responses to classroom behavior items (p=0.477), clinic behavior items (p=0.958), or general behavior items (p=0.767). The category composite scores were not significantly associated with gender, ethnicity, or age for faculty or students (p>0.05 for all).

Students reported feeling that a faculty member's drinking, other than water, during clinic was significantly more uncivil than drinking non-water beverages during class (p<0.001), but there was not a difference among faculty respondents (p=0.213). Similarly, students reported feeling that a faculty member's arriving late for clinic was significantly more uncivil than arriving late for class (p<0.001), but there was not a difference among faculty respondents (p=0.122). Both students (p<0.001) and faculty (p=0.026) reported feeling that a faculty member's leaving clinic early was significantly more uncivil than leaving class early. Both students (p<0.001) and faculty (p<0.001) reported feeling that a faculty member's answering a non-emergency phone call during class was significantly more uncivil than answering a non-emergency phone call during clinic. Similarly, both students (p<0.001) and faculty (p<0.001) reported feeling that a faculty member's non-emergency texting during class was significantly more uncivil than non-emergency texting during clinic.

Discussion

The dearth of professional literature concerning faculty incivility in dental education was the impetus for conducting this study, especially with the increasing evaluation of faculty incivility in nursing education. Nursing educators are evaluating the effect of faculty incivility on their students' educational experience, satisfaction with their institution, faculty

Table 3. Student vs. faculty agreement that each item describing faculty behavior is uncivil behavior: mean (standard deviation) and p-value for each and total in each category

Item	Students (n=201)	Faculty (n=64)	p-value
Classroom Behaviors (α=0.736)	**3.6 (0.5)**	**3.7 (0.6)**	**0.418**
Canceling class without warning (not due to an emergency).	3.4 (1.1)	4.2 (2.7)	<0.001*
Being unprepared for class.	4.2 (0.7)	4.3 (2.7)	0.380
Arriving late for class.	3.6 (0.9)	4.0 (0.8)	0.001*
Drinking, other than water, during class.	2.4 (1.2)	3.0 (1.3)	0.002*
Answering a cell phone, other than for an emergency, during class.	3.9 (0.9)	4.4 (0.8)	<0.001*
Texting, other than for an emergency, during class.	3.9 (0.8)	4.2 (1.0)	0.004*
Leaving class early.	2.7 (1.0)	3.4 (1.0)	<0.001*
Not allowing open discussion.	3.7 (0.9)	3.4 (1.1)	0.051
Delivering fast-paced lectures.	3.3 (1.0)	2.9 (1.1)	0.003*
Refusing to provide PowerPoint presentation prior to or after class.	4.2 (0.9)	2.7 (1.1)	<0.001*
Not being available outside of class.	4.2 (0.7)	3.8 (1.0)	0.005*
Clinic Behaviors (α=0.831)	**3.5 (0.7)**	**3.5 (0.8)**	**0.569**
Using a computer for nonprofessional purposes during clinic.	3.5 (1.0)	3.4 (1.1)	0.569
Eating during clinic.	3.5 (1.0)	3.7 (1.0)	0.024*
Arriving late for clinic.	4.0 (0.8)	3.9 (0.9)	0.295
Leaving clinic early.	3.9 (0.9)	3.8 (1.0)	0.526
Drinking, other than water, during clinic.	2.9 (1.1)	3.2 (1.1)	0.108
Answering a cell phone, other than for an emergency, during clinic.	3.5 (1.0)	3.3 (1.1)	0.195
Texting, other than for an emergency, during clinic.	3.4 (1.1)	3.1 (1.1)	0.044*
Reading newspaper/magazines during clinic.	3.3 (1.0)	3.5 (1.1)	0.289
General Behaviors (α=0.701)	**3.7 (0.5)**	**3.7 (0.4)**	**0.685**
Refusing to allow makeup exams, extensions, or grade changes.	3.7 (1.0)	2.8 (0.9)	<0.001*
Deviating from the course syllabus and changing assignments or test dates.	3.5 (1.1)	2.7 (1.0)	<0.001*
Being inflexible, rigid, and authoritarian.	4.0 (0.9)	3.5 (0.9)	<0.001*
Punishing the entire class for one student's misbehavior.	4.6 (0.5)	3.9 (0.8)	<0.001*
Refusing or being reluctant to answer questions.	4.4 (0.6)	3.9 (0.9)	<0.001*
Subjective grading.	4.0 (0.9)	2.8 (1.1)	<0.001*
Ignoring disruptive student behaviors.	3.8 (0.8)	4.0 (0.7)	0.059
Using profanity.	3.4 (1.0)	4.4 (0.8)	<0.001*
Challenging another faculty member's knowledge or credibility.	3.8 (0.9)	4.0 (0.9)	0.070
Socializing after hours with a select group of students.	2.6 (1.0)	3.4 (1.1)	<0.001*
Posting about work-related matters on social media.	3.6 (1.0)	4.3 (0.8)	<0.001*
Being disinterested.	4.0 (0.8)	4.0 (1.0)	0.746
Belittling or taunting students.	4.7 (0.6)	4.5 (0.8)	0.035*
Including students in friends on social media.	2.4 (0.9)	3.4 (0.9)	<0.001*

Note: Students and faculty members were asked to indicate their agreement that each item describing a potential faculty member's behavior "is uncivil behavior." Response options were 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree.

*Statistically significant difference (p<0.05)

collegiality, and the professional behaviors of nurses upon graduation.[10] The education of nurses and dental providers is similar in that both utilize faculty, student, and patient interactions in a clinical setting in addition to didactic classroom settings. This similarity justifies such evaluation when one considers that faculty incivility was reported in one study to interfere with safe clinical performance.[11]

Our study expanded on a previously published study concerning student and faculty perceptions of uncivil student behavior in dental education and used its survey as a basis for conducting this study.[18] The current study inquired about perceptions of faculty incivility in a dental education setting and found significant differences between faculty and students. Since the learning environment is influenced by both student and faculty behavior, it follows that discovering differences in student-perceived uncivil behaviors compared to faculty members could be beneficial in establishing a positive learning environment.

It is of interest to note that our results showed no difference in perceptions of uncivil faculty behavior between courses of study or when we compared by gender, ethnicity, or age for either faculty or students. At this institution, it appears that students are in relative agreement on behavior that is expected of the faculty. It also appears that the faculty are in relative agreement on behavior that is expected of each other. Also, the mean scores of both faculty and students revealed that there was not a feeling that faculty incivility existed at this institution.

While there was no significant difference between students and faculty when the behaviors were grouped categorically, we found significant differences for 22 of the 33 individual behavioral questions. There were significant differences on nine of 11 faculty behaviors grouped as classroom behaviors, two of eight behaviors grouped as clinic behaviors, and 11 of 14 behaviors grouped as general behaviors. The higher agreement between students and faculty concerning clinical behavior, as compared to classroom or general behavior, is interesting in that the same behavior was considered uncivil in a clinical setting but not so in a classroom setting.

Faculty respondents viewed the classroom behaviors of canceling class without warning not due to an emergency and arriving late as uncivil, whereas students viewed those behaviors neutrally. Students did not consider a faculty member's leaving class early to be uncivil, perhaps because that would imply they are able to leave class early as well. The clinical behavior of texting for a non-emergency was not viewed as uncivil by faculty. It is plausible that faculty members perceive work-related texts, although not emergencies, as part of fulfilling their teaching or administrative responsibilities. Interestingly, it was more acceptable by both faculty and students to text during clinic than it was in a classroom.

One of the questions that generated the greatest discrepancy between the faculty and students was about providing a PowerPoint presentation either before or after the lecture. Perhaps the students perceived that having a copy of the lecture enables them to pay better attention without having to worry about missing pertinent information while frantically writing notes. Faculty members may be hesitant to provide the PowerPoint for fear that students may not attend class or be as attentive if they are given the lecture material. Additionally, students perceived that faculty members should be available after class more than the faculty did.

On the general behaviors, there were more questions with a greater discrepancy between what faculty and students perceived as uncivil. For example, students tended to believe that a faculty member's refusing to allow make-up exams, extensions, or grade changes was uncivil, whereas faculty respondents tended to disagree. Faculty members may deem their course requirements to be fair and just and that, if a student falls under their set standard, then the student should take responsibility for his or her shortcomings. Similarly, students may perceive faculty members as being authoritative although faculty members may not see themselves the same way. Faculty members have a difficult task of modeling acceptable professional behavior while guiding possibly difficult students through learning experiences.

With respect to socializing both in person and on social media, students tended to find it acceptable to interact with faculty members outside of school hours. Students seemingly desired to interact with faculty members on a more personal basis. Faculty members, however, may perceive socializing with students outside of school as being unprofessional or crossing an invisible professional boundary.

As this was the first study on this topic set in an academic dental institution, the literature provided no basis for comparison with our results. Potential limitations of this study included the use of only one dental education institution to sample perspectives. We felt, however, that the findings could be used to determine the need for a multi-institutional study. Another limitation may be that results could be affected by non-responding students and faculty who may have feared repercussions from faculty or administration despite being assured that responses were anonymous. Even though the study's response rate was relatively high, response bias should always be considered in a survey-based study. A question regarding non-response to surveys as an uncivil behavior should be included in future studies. An additional limitation was using a survey that, while used in a previous study, was not validated.

The obvious question that now needs to be explored is whether these findings are limited to this single institution. If a multi-institutional study were undertaken, some aspects to consider are the following: What are characteristics of the institutions where the study will be undertaken? Which of these characteristics may be contributing to the feeling of faculty incivility? Are these characteristics having an effect on the learning environment?

Conclusion

This study found significant differences between students and faculty in their perceptions of uncivil behaviors by faculty members. The significant differences were found of individual faculty behaviors but not of behavior category composite scores. Classroom and clinical environments conducive to student learning are paramount in the training of dental professionals. The socialization that takes place in both of these settings serves to mold the professional behavior of students. Faculty members must be keenly aware of the behaviors they model and the influence of those behaviors on emerging professionals. Students' observing perceived uncivil faculty behavior can either reject it as inappropriate or accept and assimilate it into their own professional identity. For those students rejecting the perceived uncivil behavior, the classroom or clinic can become an unprofessional or even hostile environment that may no longer be conducive to learning.

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